205 East Park Street
Anaconda, Montana 59711
1-800-432-6145
Fax: 406-563-5956
www.aware-inc.org

Human RESOURCES

Name: _____
Last Name First Name MI

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ( ) _____ **Message Phone: ( )** _____

Are you 18 or older? Yes ☐ No ☐

Position applying for: _____

City/Town: _____

POSITION Check all service areas that you are interested in. Your application may be submitted for *open* positions in that service area	**Youth Service** ☑	**Adult Service** ☑	**Administrative** ☑
	☐ Residential	☐ Residential	☐ Training
	☐ School Based	☐ Work Services	☐ Maintenance
	☐ Support Services	☐ Transportation	☐ Human Resources
	☐ Case Management	☐ Case Management	☐ Accounting
	☐ Early Head Start		☐ IT

How did you hear about the position:	☐ Job Service	☐Newspaper	☐AWARE employee
	☐ AWARE web page	☐Family/Friend	☐College Career Service
	Other		

Have you ever worked for A.W.A.R.E., Inc.? Yes ☐ No ☐

If yes Name Used: _____ Location: _____

Dates worked: _____

Military Services:

Branch of Service: _____ Dates of Service: _____

Duties/Special Training: _____

A.W.A.R.E. Inc.

Employment History

Please start with your present employer.
You may print additional employment history pages if needed.

Employer Name Address				Phone:
Job Title:	Employment Date	/ /	to / /	
Supervisor	Starting/Ending Wage	$	$	
Duties:				
Reason for Leaving:				

Employer Name Address				Phone:
Job Title:	Employment Date	/ /	to / /	
Supervisor	Starting/Ending Wage	$	$	
Duties:				
Reason for Leaving:				

Employer Name Address				Phone:
Job Title:	Employment Date	/ /	to / /	
Supervisor	Starting/Ending Wage	$	$	
Duties:				
Reason for Leaving:				

REFERENCES

Please do not list relatives or former employers

Name	Phone - Work	
	Phone - Home	
Relationship		

Name	Phone - Work	
	Phone - Home	
Relationship		

Name	Phone - Work	
	Phone - Home	
Relationship		

Related Information:

1) Have you ever been convicted of a felony? Yes ☐ No ☐
2) Have you ever received a vehicular citation? Yes ☐ No ☐
3) Have you had a valid Driver License for 3 or more years? Yes ☐ No ☐

If you answered yes to questions 1 or 2 above, please explain**:**

Names of friends/relatives employed by A.W.A.R.E., Inc.: _____

Signature: _____Date: _____

EDUCATION

High School Name/Address Phone Did you receive a diploma or equivalency certificate? Yes ☐ No ☐		
College, University or additional schooling Name, Location, and Dates of Attendance	Major/Minor	Degree Received/Date
Name used while attending:		
Post Graduate Name, Location, and Dates of Attendance		Degree Received /Date
Name used while attending:		

Training Courses Name, Location, and Dates of Attendance	Title of Course	Date completed	Current

I AUTHORIZE THE INSTITUTION(S) NAMED ABOVE TO RELEASE STATED INFORMATION TO A.W.A.R.E., INC.

Signature: _____ **Date:** _____

AUTHORIZATION FORM

Personnel Department

In order to complete your application file, it is necessary for us to complete a background reference.

Please sign and date the authorization release below.

AUTHORIZATION: I, the undersigned, hereby authorize any agency, institution or business, including my present employer to furnish any and all information contained in my records for the purpose of an employment background investigation.

I also authorize personal references to furnish the requested information they may have concerning me, and do hereby release such persons from all liability and damage for issuing such information.

SIGNED: _____

DATE: _____

DPHHS-QAD/CRL-018
(Rev 9/01)

STATE OF MONTANA
Department of Public Health and Human Services
Quality Assurance Division

RELEASE OF INFORMATION (For Licensed Youth and Adult Care Providers)
Criminal and Protective Service Background Checks

PLEASE TYPE OR PRINT LEGIBLY

Section A

Facility Name: **AWARE Inc.** Facility Location: _____

Applicant/Employees Name:

_____

First Middle Maiden Last

Aliases/Other Names Used:

_____

_____

Applicant/Employee Current Address:

_____

Phone #: _____ Date of Birth: _____ Sex: [ ] M [ ] F

Drivers License #_____Social Security _____

Section B

Please list below where you have resided in the past 5 years. Attach additional pages if necessary. QAD will complete a State of Montana Criminal and Protective Service background check at no cost to the applicant/employee. However, the applicant/employee will be responsible for obtaining the results and assuming the cost of any out of state background checks.

City	County	State	Dates of Residency (From-To)

Section C

I understand that any information obtained from these checks will be used by the Department to evaluate my employer's application or my own application as a licensed provider. I hereby authorize any law enforcement, protective services agency or the Montana Motor Vehicle Division to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services and (If applicable) to my employer or perspective employer as indicated in Section A of this form.

A copy of this form is as valid as the original.

Signed: _____Date: _____

To be signed in front of a Notary

To be completed by Notary Public:

Taken, sworn and subscribed before me this_____day of _____A.D. 20_____

Notary Public for the State of Montana Residing at: _____My Commission Expires: _____

This information is an essential part of the license application and is required in accordance with 50-5-205(1)(c), MCA

DPHHS-QUAD/CLR-005
(Rev 3/00)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Quality Assurance Division
COMMUNITY RESIDENTIAL LICENSING PROGRAM
PERSONAL STATEMENT OF HEALTH FOR LICENSURE

NAME (Please Print) Phone Number

A.W.A.R.E., Inc
Facility Name

205 East Park Street Anaconda, Montana 59711
Address City, State, Zip

Social Security Number Birth Date

Pursuant to ARM 37.97.130(3) A personal statement of health for licensure form provided by the department must be completed for each person subject to requirements of this real. This form must be submitted to the department with the initial application for licensure and annually thereafter.

The Licensing Specialist completing the licensure study and the Community Residential Licensing Program Manager who issues the license will review this form. In some cases, The Answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your response. The purpose of he questions is to help determine if you have health issues that may affect your ability to safely provide care.

Please answer the following questions by entering an "X" in the appropriate box for each question.

1. [ ] Yes [ ] No Do you have any physical or mental health problems which might affect your ability to provide care. (If yes please explain in Section 6 on reverse side.)

2. [ ] Yes [ ] No Have you been convicted of a crime involving child or elder abuse or neglect, including sexual abuse, physical assault, or other acts of violence? (If yes please explain in Section 6 on reverse side.)

3. [ ] Yes [ ] No Have you ever been named as a perpetrator in a substantiated report of child or adult abuse or neglect (or exploitation of an adult?) (If yes please explain in Section 6 on reverse side.)

4. [ ] Yes [ ] No Are you currently diagnosed or receiving therapy or medication for mental health problem which might affect your ability to provide care? (If yes please explain in Section 6 on reverse side.)

5. [ ] Yes [ ] No Have you received counseling or treatment related to chemical dependency on drugs or alcohol within the past three years? (If yes please explain in Section 6 on reverse side.)

YOUR SIGNATURE IS REQUIRED ON THE BACK SIDE OF THIS FORM

The department may request additional supportive documentation from your medical practitioner, psychologist or counselor. If determined to be necessary, the Licensing Specialist will discuss with you the type of additional information needed. If an evaluation or statement is needed, the specialist can assist you in completing the authorization form for your physician or other appropriate professional. **Any evaluations, tests, or visits to your physician or other professional(s) must be paid by you.**

6. Please use the space below to explain any "Yes" answers marked in questions 1 through 5.

PLEASE READ, THEN SIGN AND DATE:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or for adverse license action in accordance with ARM 37.97.115. I understand this information is confidential and to be used by the Department of Public Health and Human Service for the administration of the licensure program. I hereby consent to the use of this information for such purposes.

SIGNATURE: _____ DATE: _____